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FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO Oct. 24 2018
BY [signature] ANALYST

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: BRUCE M. STARK, M.D. 4418 Vineland Ave., Suite 102 Toluca Lake, California 91602-3457 Physician's and Surgeon's Certificate No. G 72204, Respondent.	Case No. 800-2017-035866 **A C C U S A T I O N**

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer ("Complainant") brings this Accusation solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs ("Board").

2. On August 6, 1991, the Board issued Physician's and Surgeon's Certificate Number G 72204 to Bruce M. Stark, M.D. ("Respondent"). That Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on February 28, 2019, unless renewed.

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JURISDICTION

3. This Accusation is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code ("Code") unless otherwise indicated.

4. Section 2234 of the Code states:

"The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

"(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.

"(b) Gross negligence.

"(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

"(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

"(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

"(d) Incompetence.

"(e) The commission of any act involving dishonesty or corruption which is substantially related to the qualifications, functions, or duties of a physician and surgeon.

"(f) Any action or conduct which would have warranted the denial of a certificate.

"(g) The practice of medicine from this state into another state or country without meeting the legal requirements of that state or country for the practice of medicine. Section 2314 shall not apply to this subdivision. This subdivision shall become operative upon the implementation of the

proposed registration program described in Section 2052.5.

"(h) The repeated failure by a certificate holder, in the absence of good cause, to attend and participate in an interview by the board. This subdivision shall only apply to a certificate holder who is the subject of an investigation by the board."

5. Section 2266 of the Code states: "The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

FIRST CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

6. Respondent is subject to disciplinary action under Code section 2234, subdivision (c), in that he engaged in repeated negligent acts with respect to the care and treatment of Patient A. The circumstances are as follows:

7. From approximately March of 2009, to approximately August of 2011, and on or about January 11, 2012, Respondent treated Patient A, a then fifty-five-year-old male. Respondent treated him for chronic low back pain and managed his medications. Respondent also treated him for other medical conditions, including, but not limited to, obesity, asthma, allergies, hyperlipidemia, Deep Vein Thrombosis, hypertension, and anxiety disorder.

8. Respondent tried various narcotic pain medications, including Morphine immediate release and extended release pills,[1] Acetaminophen-Hydrocodone,[2] Oxycodone,[3] and Fentanyl

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[1] Morphine (MS Contin, Oramorph SR (Oral)) is an opioid pain medication. It is a Schedule II controlled substance as defined by part 1308.12(b)(1)(ix) of Title 21 of the Code of Federal Regulations and California Health and Safety Code section 11055, subdivision (b)(1)(L). It is a dangerous drug as defined in California Business and Professions Code section 4022.

[2] Hydrocodone is an opioid pain medication. Acetaminophen is a less potent pain reliever that increases the effects of hydrocodone. Acetaminophen-Hydrocodone (Norco, Lortab, Vicodin) is a Schedule II controlled substance as defined by 21 Code of Federal Regulations part 1308.12(b)(1)(vi) and California Health and Safety Code section 11055, subdivision (b)(1)(I). It is a dangerous drug as defined in California Business and Professions Code section 4022.

[3] Oxycodone (OxyContin) is an opioid pain medication. It is a Schedule II controlled substance as defined by part 1308.12(b)(1)(xiii) of Title 21 of the Code of Federal Regulations and California Health and Safety Code section 11055, subdivision (b)(1)(M). It is a dangerous drug as defined in California Business and Professions Code section 4022.

patches[4] for approximately two to three years. In or around 2011 to 2012, Respondent eventually maintained Patient A on a combination of morphine short- and long-acting medications. In addition to the opiate prescriptions, Respondent also intermittently prescribed diazepam 10 mg,[5] Ambien 10 mg,[6] and alprazolam 1 mg.

9. During the time period that Respondent provided care and treatment to Patient A, Patient A was also receiving controlled substances, including opiates, from other physicians. For example, during an approximately one-month period from July 7, 2010, to August 8, 2010, he received three separate Norco prescriptions totaling 480 tablets within 30 days, in addition to the regular morphine prescriptions that he received from Respondent.

10. Patient A showed other aberrant drug-related behaviors and his family reported medication overuse to Respondent.

11. On or about January 22, 2010, and April 15, 2010, Respondent prescribed Oramorph SR 60 mg, 90 tabs, and Acetaminophen-Hydrocodone 325 mg-10 mg, 180 tabs, for a total of approximately 240 mg Morphine Equivalent Daily Dose ("MEDD").[7] On July 20, 2010, Respondent assessed Patient A's pain to be stable on the current opiate regimen (Oramorph SR and Norco) of approximately 240 mg MEDD.

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[4] A Fentanyl Patch is a narcotic pain medicine. Fentanyl is used for managing severe chronic pain. Fentanyl is a Schedule II controlled substance as defined by part 1308.12, subdivision (c)(9) of Title 21 of the Code of Federal Regulations and California Health and Safety Code section 11055, subdivision (c)(8). It is a dangerous drug as defined in California Business and Professions Code section 4022.

[5] Benzodiazepines are a class of drugs that produce Central Nervous System depression and are most commonly used to treat insomnia and anxiety. They include alprazolam (e.g., Xanax), lorazepam (e.g., Ativan), diazepam (e.g., Valium), and temazepam (Restoril). They are Schedule IV controlled substances as defined by 21 Code of Federal Regulations part 1308.14(c)(2), (c)(16), (c)(30), (c)(5) and California Health and Safety Code section 11057, subdivisions (d)(1), (d)(9), (d)(16), and (d)(29). They are dangerous drugs as defined in California Business and Professions Code section 4022.

[6] Zolpidem (Ambien) is a sedative, also called a hypnotic. It is used to treat insomnia. It is a Schedule IV controlled substance as defined by 21 Code of Federal Regulations part 1308.14(c)(54) and California Health and Safety Code section 11057, subdivision (d)(32). It is a dangerous drug as defined in California Business and Professions Code section 4022.

[7] MEDD of opioids is a numerical standard against which most opioids can be compared, giving an apples-to-apples comparison of each medication's potency. By converting the dose of an opioid to a morphine equivalent dose, a clinician can determine whether a cumulative daily dose of opioids approaches an amount associated with increased risk.

12. On or about November 23, 2010, Respondent prescribed Oramorph SR 60 mg, 180 tabs, and Oxycodone 30 mg, 180 tabs, for a total of approximately 450 mg MEDD. Respondent was informed that Patient A's mother did not want him on opiates.

13. On or about December 21, 2010, Respondent prescribed Morphine 60 mg, 180 tabs, and Oxycodone 30 mg, 180 tabs, for a total of approximately 630 mg MEDD.

14. On or about January 18, 2011, Respondent prescribed Oramorph SR 60 mg, 180 tabs, with MS Contin immediate release 30 mg, 120 tabs, for a total of approximately 480 mg MEDD. Similarly, on or about March 15, 2011, Respondent prescribed MS Contin extended release 60 mg, 180 tabs, with MS Contin immediate release 30 mg, 120 tabs, for a total of approximately 480 mg MEDD.

15. On or about April 12, 2011, Respondent increased the pain medications to a MEDD of approximately 540 mg (Oramorph SR 60 mg, 180 tabs, with MS Contin immediate release 30 mg, 180 tabs), but the prescriptions were written in 10-day intervals to minimize abuse. Respondent received a letter from Patient A's mother informing him that Patient A was overmedicated with pain medications. Respondent wrote Patient A's mother a note asking her to come with Patient A to his appointment to address her concerns.

16. On or about May 11, 2011, Respondent saw Patient A with his mother. Patient A's mother informed Respondent that Patient A would frequently fall and could not get up on his own. He would lay on the kitchen floor for hours and could not move for hours. Patient A did not dispute his mother's description of his condition. Respondent reduced the morphine therapy to a total of approximately 330 mg MEDD (MS Contin extended release 60 mg, 120 tabs, with MS Contin immediate release 30 mg, 90 tabs).

17. On or about June 7, 2011, Respondent saw Patient A for care and treatment. Patient A was less lethargic and more focused with appropriate mood. Respondent prescribed morphine therapy (Morphine extended release 60 mg, 120 tabs, and Morphine immediate release, 30 mg, 120 tabs) for a total of approximately 360 mg MEDD; Valium 10 mg, 90 tabs; and Gabapentin 600 mg, 180 tabs.

18. On or about August 10, 2011, Respondent noticed that Patient A was lethargic and

unfocused. He counseled Patient A about over-medicating and mixing benzodiazepines with opiates. Urine testing was consistent with his controlled substance prescriptions. Respondent refilled his opiate medications (Morphine extended release 60 mg, 90 tabs, and Morphine immediate release 30 mg, 60 tabs), but only allowed two-week prescriptions for closer monitoring. The total MEDD was increased to approximately 480 mg based on his prescriptions.

19. On or about January 11, 2012, Respondent treated Patient A, who had been off opiates for approximately three to four months.

20. According to the patient's medical record, dated January 11, 2012, Respondent refilled 14 of his prescription medications, including his chronic opiate medication MS Contin 60 mg, 180 tablets, for a total of approximately 360 mg MEDD.

21. A urine toxicology screen, dated on January 11, 2012, showed no trace of opiates, as Patient A had not been prescribed opiates due to his inability to see Respondent.

22. On January 15, 2012, Patient A died of acute morphine intoxication.

23. On January 11, 2012, Respondent engaged in repeated negligent acts as follows:

24. Respondent departed from the standard of care when he failed to properly risk assess the patient's addiction risks and failed to obtain a Controlled Substance Utilization Review and Evaluation System ("CURES")[8] report. It is unclear why Patient A sought out Respondent for care after approximately three to four months of abstinence and opiate-free therapy. Respondent assessed Patient A to be in great pain physically. Respondent should have obtained a CURES report either prior to the visit or during the visit to monitor the patient for aberrant or diversion behaviors and to minimize any risk of opiate toxicity, overdose, or doctor-shopping. If a CURES report was unavailable on the day of the visit, Respondent could have prescribed a small quantity of opiates if indicated until a full CURES report was available.

25. Respondent departed from the standard of care when he prescribed two benzodiazepines (diazepam and alprazolam) and a sleep sedative (zolpidem) with high dose morphine to a patient with chronic pulmonary conditions (asthma and likely obesity-related

[8] CURES refers to the Controlled Substance Utilization Review and Evaluation System, which is a government database containing information on Schedule II through IV controlled substances dispensed in California.

obstructive sleep apnea). Benzodiazepines and opiate medications both cause central nervous system depression and can decrease respiratory drive. Concurrent use is likely to place patients at greater risk for potentially fatal overdose.

26. The combination of two benzodiazepines exposed Patient A (a patient with chronic pulmonary disorders) to the additive risks of respiratory sedation from benzodiazepine overdose. The risk was further increased with the combination of two benzodiazepines and high dosage morphine. Patients with pulmonary conditions such as Patient A often have higher risks of accidental respiratory complications from the combination of two benzodiazepines and high dosage morphine, especially if their sleep apnea or asthma condition is not adequately treated. The combination of morphine, two benzodiazepines, and a sleep sedative exposed Patient A to the dangers of accidental respiratory arrest from overdose.

27. Respondent departed from the standard of care when he maintained inadequate and inaccurate records. The progress note for the January 11, 2012 visit does not reflect a comprehensive evaluation of Patient A's back pain. A detailed back examination is not documented, such as the degree of flexion and extension of the lower spine. The documentation of the 4 A's of pain assessment (analgesic relief, activities of daily living, adverse side effects, and aberrant behaviors) in monitoring the efficacy of opiate pain medications was lacking. The proper dosage and quantity of morphine refilled was not documented. Informed consent for using benzodiazepines and high dosage morphine was not documented. A CURES check was not documented.

28. Respondent departed from the standard of care when he failed to prescribe morphine at a much lower dose during the January 11, 2012, visit and to titrate slowly and accordingly since Patient A had in a way "successfully" detoxed off of morphine. He was off of opiates for approximately three to four months with withdrawal symptoms. His urine drug screen on January 11, 2012 was consistent with no trace of opiates. As a result, his tolerance to morphine was lower and his sensitivity was higher to the effects of morphine. However, Respondent refilled the morphine at roughly the same excessive dosage of approximately 360 mg MEDD at the same directions. By doing so, Respondent exposed Patient A to the increased risk of accidental

overdose due to the patient's lower morphine tolerance and improved sensitivity from the previous drug abstinence.

29. Respondent's acts and/or omissions as set forth in paragraphs 7 through 28, inclusive above, whether proven individually, jointly, or in any combination thereof, constitute repeated negligent acts pursuant to Code section 2234, subdivision (c). Therefore, cause for discipline exists.

SECOND CAUSE FOR DISCIPLINE

(Inadequate and Inaccurate Recordkeeping)

30. Respondent is subject to disciplinary action under Code section 2266 in that Respondent maintained inadequate and inaccurate records with respect to his care and treatment of Patient A. The circumstances are as follows:

31. Paragraphs 7 through 28 are incorporated by reference as if fully set forth herein.

32. The progress note for the January 11, 2012 visit does not reflect a comprehensive evaluation of Patient A's back pain. A detailed back examination is not documented, such as the degree of flexion and extension of the lower spine. The documentation of the 4 A's of pain assessment (analgesic relief, activities of daily living, adverse side effects, and aberrant behaviors) in monitoring the efficacy of opiate pain medications was lacking. The proper dosage and quantity of morphine refilled was not documented. Informed consent for using benzodiazepines and high dosage morphine was not documented. A CURES check was not documented.

33. Respondent's acts and/or omissions as set forth in paragraphs 31 through 32, inclusive above, whether proven individually, jointly, or in any combination thereof, constitute inadequate and inaccurate record keeping pursuant to Code section 2266. Therefore, cause for discipline exists.

THIRD CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

34. Respondent is subject to disciplinary action under Code section 2234 in that he engaged in unprofessional conduct with respect to the care and treatment of Patient A. The

circumstances are as follows:

35. Paragraphs 6 through 33 are incorporated by reference as if fully set forth herein.

36. Respondent's acts and/or omissions as set forth in paragraph 35, inclusive above, whether proven individually, jointly, or in any combination thereof, constitute unprofessional conduct pursuant to Code section 2234. Therefore, cause for discipline exists.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate Number G 72204, issued to Respondent Bruce M. Stark, M.D.;

2. Revoking, suspending or denying approval of his authority to supervise physician assistants and advanced practice nurses;

3. If placed on probation, ordering him to pay the Board the costs of probation monitoring; and

4. Taking such other and further action as deemed necessary and proper.

DATED: October 24, 2018

KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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